

My Heart Care Action Plan

My name:

Date:

My address:

Name of my health care provider:

Phone number of my provider:

Who to contact for me in case of an emergency (family member or friend to call):

Name:

Phone number:

Nurse First Heart Program phone number : 1-800-330-7847

I should talk to my provider TODAY if:

1. It is harder than usual for me to breathe.
2. I have more swelling than usual in my hands, feet or ankles.
3. I gain _____ pounds or more in one week.

I should get help RIGHT AWAY if:

1. I have chest pains.
2. My heart feels like it is beating fast for 5 minutes or more.
3. One side of my body starts tingling or feels weak.
4. I have a very hard time breathing.



I should ask my provider these questions:

- | | | |
|--|------------------------------|-----------------------------|
| 1. Should I take an Ace-inhibitor to protect my heart? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 2. Should I take a beta-blocker to protect my heart? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 3. Should I get a flu shot every year in the fall? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 4. Should I get my cholesterol checked every year? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 5. What should my blood pressure be? _____ / _____ | | |



(over)



I should do these things to help me stay healthy:

1. Weigh myself every morning after I go to the bathroom and before I eat.
2. Write down what I weigh every day.
3. Tell my provider about any problems I have with my medicines.
4. Keep taking my medicine until my provider tells me to stop.
5. Not smoke.
6. Get checkups when my provider tells me to.
7. Get my blood pressure checked at each visit.
8. Eat healthy and get some exercise every day.

I exercise or am active _____ days each week for _____ minutes.

My medicines:

Name of my medicine:	How much I should take:	How often I should take this medicine:	This medicine is for:

Other things I should do:

